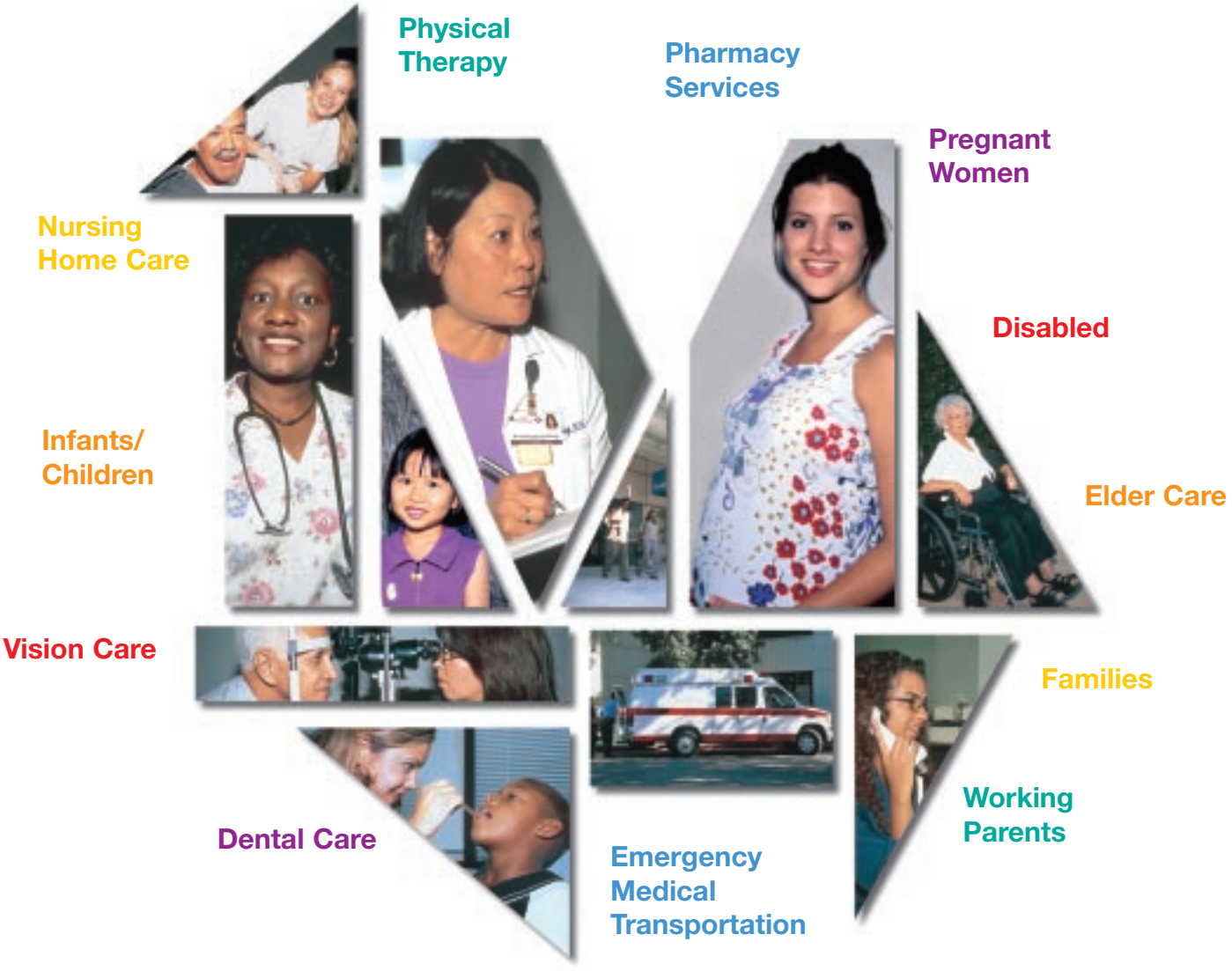
HEALTH CARE COVERAGE

FOR PEOPLE WITH LIMITED INCOME OR RESOURCES

MEDI-CAL

NEW MAIL-IN APPLICATION AND INSTRUCTIONS



For *FREE* help to apply for Medi-Cal, contact your local welfare office.

What is Medi-Cal?

- Health care coverage for qualifying persons who live in California, who have income and resources below established limits

Who can get Medi-Cal?

- Persons 65 or older or
- Persons who are under 21 years of age
- Certain adults, between 21 and 65 years of age, if they have minor children living with them
- Persons who are blind or disabled
- Pregnant women
- Persons receiving nursing home care
- Certain Refugees, Asylees, Cuban/Haitian Entrants

Do I have to be a U.S. citizen to get Medi-Cal?

- No, documented and undocumented aliens may be eligible for Medi-Cal. Some persons may receive pregnancy related and emergency services only; others are eligible for full Medi-Cal benefits depending on their alien status

When Medi-Cal says "a minor child," what does it mean?

- A child married or unmarried under 21 years of age living in your home or away at school

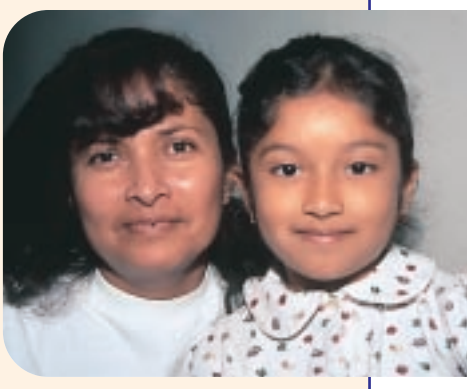
What do I do to get Medi-Cal coverage?

- Complete and send in the enclosed application
- Send copies of any required documentation (See instructions)

How can my family and I qualify for Medi-Cal coverage?

If you are in one of the groups listed in "Who can get Medi-Cal?" above:

- We look at your income and subtract some expenses you pay to decide your family's countable income for Medi-Cal
- We look at things you and your family own (bank accounts, vehicles, etc.) to see if you meet the resource limit. **Please Note:** Not all the things you or your family own are counted; your local welfare office can give you more information



If I do not fall into one of the covered groups, how can I get coverage?

- Contact your local welfare office for information about medical services in your county

When Applying For Medi-Cal Health Coverage
What Should I Do If...

I have an immediate need for health care services, such as severe illness or pregnancy.

- Take this application directly to the nearest welfare office to start the application process.

I have the application, but need help.

- Read Instructions carefully.
- Contact your local welfare office for help.
- Ask a friend or relative to help you.

My spouse or I are entering a nursing home and applying for Medi-Cal.

- Immediately contact your local welfare office for a copy of the notice regarding standards for Medi-Cal eligibility form (DHS 7077). This form will explain certain exempt resources, certain protections against spousal impoverishment, and certain circumstances under which an interest in a home may be transferred without affecting Medi-Cal eligibility.

I filled out the application and want to mail it.

- Complete the application and mail it to your nearest local welfare office.

I'm homeless or do not have a mailing address.

DO NOT MAIL THIS APPLICATION.

- Go to the nearest local welfare office to turn in this application.

I'm a minor/teenager and want confidential Minor Consent Services, for family planning, pregnancy related care, mental health, drug and alcohol abuse treatment/ counseling, sexually transmitted diseases (STD) or sexual assault.

- To maintain confidentiality, you must take this application to the local welfare office or eligibility worker site.

DO NOT MAIL IT.

I want to ask for Medi-Cal in person. I do not want to mail the application.

- Contact your local welfare office and ask for an interview to apply in person.

Remember, whether you take your application to the local welfare office or you mail it, you should *not pay* anyone to help you with this application.

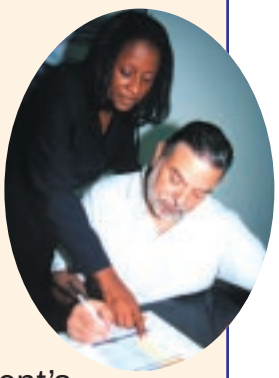
www.dhs.ca.gov

For *FREE* help to apply for Medi-Cal, contact your local welfare office.

How to fill out the application

- **Tear out the application**
- **Read the instructions completely**
- **Fill out as much of the application as you can**
- **Include requested documentation (See instructions)**
- **If help is needed contact the local welfare office**
- **Do not delay in sending in your application**

Whose information should you put on this application?



- If you are an adult not living with a spouse, and you have no children, enter your own information.
- If you are legally married and living together, enter your and your spouse's information.
- If you are legally married but one or both of you are living in a nursing home or board and care facility, enter your and your spouse's information.
- If your children are under 21 years of age and living with you and their other parent, enter your own information, your children's and the other parent's.
- If you are under 21 years of age and not living with your parents, enter your own information.
- If you are an unmarried minor under 21 years of age living with your parent(s) and asking for Minor Consent confidential services, enter your own information.

What will happen after I send in my application?

- The local welfare office will notify you within 10 working days that they received your application. They will give you the name of someone you can contact for more information about your application.
- You will receive a packet from the county with additional program information.
- You may receive a request for additional information that the county will need in order to determine your eligibility.
- In most instances the local welfare office will determine your eligibility within 45 days and notify you in writing of that decision. An eligibility determination based on disability may take up to 90 days.
- If you are determined eligible, depending on what county you live in, you may be able to choose a health plan by completing a separate enrollment form.
- If you do not qualify for no-cost Medi-Cal and you wish to apply for the Healthy Families program, the local welfare office will forward this application to that program.

PRINT

APPLICATION FOR MEDI-CAL

CLEAR

To complete this form, use the instructions. Print clearly. Use black or blue ink only.

TEAR HERE

SECTION 1 Tell us about the person who wants Medi-Cal for themselves, their family or children in their care.

1 LAST NAME	FIRST NAME		MIDDLE INITIAL
2 HOME ADDRESS (NUMBER AND STREET). **DO NOT LIST A P.O. BOX** UNLESS HOMELESS		3 APARTMENT NUMBER	4 HOME PHONE # ( )
5 CITY	6 COUNTY/STATE *Select County* CA	7 ZIP CODE	8 WORK PHONE # ( )
9 MAILING ADDRESS (IF DIFFERENT FROM ABOVE) OR P.O. BOX		10 APARTMENT NUMBER	11 MESSAGE PHONE # ( )
12 CITY			13 ZIP CODE
14A WHAT LANGUAGE/DIALECT DO YOU SPEAK BEST?		14B WHAT LANGUAGE DO YOU READ BEST?	

SECTION 2 Tell us about the person listed in Section 1, his or her family and the children they care for, even if they don't want coverage.

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
15 Name: Last					
First					
Middle					
16 Relationship to person in Section 1.					
17 If address where living is not the same as listed in Section 1, put address where living:					
18 Gender:	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
19 Marital Status:	❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed
20 Name of spouse(s) of married minors in the home.					
21 Date of Birth:	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR
22 Pregnant:	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Due Date:	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR
23 Has a physical, mental or emotional disability?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Disability expected to last:	❑ 30 Days or More ❑ 12 Months or More	❑ 30 Days or More ❑ 12 Months or More	❑ 30 Days or More ❑ 12 Months or More	❑ 30 Days or More ❑ 12 Months or More	❑ 30 Days or More ❑ 12 Months or More

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SECTION 2 Continued

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
24 Has any one ever received **cash aid, SSI, Food Stamps** or **Medi-Cal**?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
If "Yes," under what name?					
25 Medi-Cal benefits BIC card number, if you have it:					
26 Wants Medical benefits?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
27 Do you own or are you buying a home outside California?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

SECTION 3 Answer for *all* children in Section 2.

Child 1	Child 2	Child 3	Unborn
28 Mother's Name:	Mother's Name:	Mother's Name:	Mother's Name:
Is Mother: ❑ Employed ❑ Disabled ❑ Unemployed ❑ Deceased ❑ Absent	Is Mother: ❑ Employed ❑ Disabled ❑ Unemployed ❑ Deceased ❑ Absent	Is Mother: ❑ Employed ❑ Disabled ❑ Unemployed ❑ Deceased ❑ Absent	Is Mother: ❑ Employed ❑ Disabled ❑ Unemployed
29 Father's Name:	Father's Name:	Father's Name:	Father's Name:
Is Father: ❑ Employed ❑ Disabled ❑ Unemployed ❑ Deceased ❑ Absent	Is Father: ❑ Employed ❑ Disabled ❑ Unemployed ❑ Deceased ❑ Absent	Is Father: ❑ Employed ❑ Disabled ❑ Unemployed ❑ Deceased ❑ Absent	Is Father: ❑ Employed ❑ Disabled ❑ Unemployed ❑ Deceased ❑ Absent

SECTION 4 List *all* income/money received by persons listed in Section 2.

30 NAME OF PERSON RECEIVING INCOME/MONEY	31 SOURCE OF INCOME/ MONEY RECEIVED (Employment, social security)	32 HOW MUCH INCOME/MONEY IS RECEIVED	33 HOW OFTEN INCOME/ MONEY RECEIVED (Monthly, bimonthly, weekly, biweekly, daily)

SECTION 5 Give information about the listed expenses/cost paid by *all* persons listed in Section 2.

TYPE OF PAYMENT YOUR FAMILY MAKES	34 NAME OF PERSON WHO PAYS	35 MONTHLY AMOUNT PAID
Child Support		
Alimony		
Other Health Insurance Premium		
Medicare Premium		

36 CHILD CARE OR DEPENDENT CARE *(List child's or dependent's name)*	37 AGE	38 NAME OF PERSON WHO PAYS	39 MONTHLY AMOUNT PAID
1.			
2.			
3.			
4.			

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SECTION 6 *Skip this Section if you are **only** applying for children under 19 and/or pregnant women (pregnancy related services only).*

Otherwise answer for *all* persons listed in Section 2.

40	Does anyone have cash or uncashed checks? If "Yes," list amount here _____ (See instructions)	❑ Yes ❑ No
41	Does anyone have a checking, savings account, or life insurance? (See instructions)	❑ Yes ❑ No
42	Is there one car or more in the household? (See instructions)	❑ Yes ❑ No
43	Does anyone have a court ordered settlement or judgement? (See instructions)	❑ Yes ❑ No
44	Does anyone have Long-Term Care insurance? (See instructions)	❑ Yes ❑ No
45	Does anyone own any items such as stocks, bonds, retirement funds, trusts, real estate, motor vehicles for a business, business accounts, promissory notes, mortgages, deeds of trust, recreational vehicles, burial trusts or funds, annuities, jewelry (not heirloom or wedding), oil or mineral rights? (See instructions)	❑ Yes ❑ No
46	Has anyone listed on this form, transferred, sold, traded or given away any items such as those listed above in the last 30 months? (See instructions)	❑ Yes ❑ No
47	Have any items listed in this section been spent or used as security for medical costs? (See instructions)	❑ Yes ❑ No

SECTION 7 Answer *only* for persons who want Medi-Cal.

		Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
48	Social Security #:					
		You may be able to receive Medi-Cal even if you do not have a Social Security Number.				
49	Place of Birth: *State or Country.*					
50	U.S. Citizen or National? If "No," write in date of entry into U.S.	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR
51	Living in a Long-Term Care or Board and Care Facility?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
	If "Yes," name of facility: Do you intend to return home?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
	Do you intend to return home within six months?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
52	Has health/dental or vision coverage?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
53	Had medical expenses within the 3 months before the month you applied and want Medi-Cal for those expenses.	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
54	Lawsuit pending due to accident or injury?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

TEAR HERE

SECTION 7 Continued

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
55 Current or past U.S. Military Service for adults, spouse or child's parents?	❑ Yes ❑ No ❑ Self ❑ Spouse ❑ Parent	❑ Yes ❑ No ❑ Self ❑ Spouse ❑ Parent	❑ Yes ❑ No ❑ Self ❑ Spouse ❑ Parent	❑ Yes ❑ No ❑ Self ❑ Spouse ❑ Parent	❑ Yes ❑ No ❑ Self ❑ Spouse ❑ Parent
56 Ethnicity (race): (optional)					
57 In school full time?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
58 Living away from home?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

SECTION 8 Information Release (Optional).

59 If family member cannot get no-cost Medi-Cal but may be able to get low-cost health care coverage, can the local welfare office send this form to the Healthy Families Program? ❑ Yes ❑ No

60 I got help from (give name of person) _____ when I filled out this application. I agree that the local welfare office may give them information about the status of this application. ***Applicant please initial*** _____

SECTION 9 Signature and Certification.

61 I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application, and the documents given are correct and true to the best of my knowledge and belief.

I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.

Signature _____ Date _____

Witness Signature *(If person signed with a mark)* _____ Date _____

Signature of person helping Applicant fill out the form _____ Telephone Number _____ Relationship to Applicant _____ Date _____

Signature of person acting for Applicant/Beneficiary _____ Telephone Number _____ Relationship to Applicant _____ Date _____

For information about any of the following programs, check the box(es) below and information will be sent to you. See the Medi-Cal brochure, "Health Care for Families with Children" or visit our website, www.dhs.ca.gov

❑ Personal Care Service Program (PCSP). A program for in-home care.

❑ Access for Infants, and Mothers (AIM). A program to help pregnant women with moderate income obtain health care.

❑ Woman, Infants and Children Nutrition Program (WIC). A nutrition program for pregnant and postpartum women and children under 5.

❑ Family Planning

❑ Child Health and Disability Program (CHDP). Preventive healthcare for children and youth. Do you want your children or youth referred to the CHDP program? ❑ Yes ❑ No

INSTRUCTIONS

Please read before beginning application.

SECTION 1

Tell us about the person who wants Medi-Cal for themselves, their family or children in their care.

Question 1:
Enter the name of the person who wants Medi-Cal, or the parent/caretaker of the children who want Medi-Cal.

Questions 2-8:
Enter the address and telephone numbers of the person who wants Medi-Cal.

Questions 9-13:
Enter the phone number and mailing address (if different than home address provided in #2) of the person who wants Medi-Cal. This is the address where all information regarding the application and health benefits will be mailed.

Question 14A-B:
Enter the language you speak and/or read best.

Send proof of identity. Only one person (a parent or caretaker) in a family needs to provide an identity document. Send a **photocopy** of one of the following identity items:

- California driver license
- Identification card issued by the Department of Motor Vehicles
- U.S. citizenship or alien status documents (passport).
- School identification card
- Birth certificate
- Marriage record
- Social Security card or document containing a Social Security number.
- Divorce decree
- Work badge, building pass
- Adoption record
- Court order for name change
- Church membership or baptismal confirmation certificate

Identity proof is not needed for

- Persons in an institution
- Children in a family, if identity of one parent has been established
- Children requesting Medi-Cal for Minor Consent services
- The spouse of a person whose identity has been verified

SECTION 2

Tell us about the person listed in Section 1, whether or not they want Medi-Cal, his or her family and the children they care for.

If you are applying for more than 5 people, use a separate piece of paper or a photocopy of pages A1, A2, A3 and A4 of the application, to give us information about the additional persons.

Who counts as an adult?

- Persons 21 years of age or older
- Persons under 21 years of age who is not living in the home of their parent or caretaker relative and is not claimed as a tax dependent

Who counts as children?

- All natural and adoptive children under 21 living in the home
- All natural and adoptive children between 18 and 21 years of age, away from home and claimed as a tax dependent
- All stepchildren under age 21 living in the home

Question 15:
Write the last, first and middle name of each person in the house.

SECTION 2 Continued

Question 16:
How is each person related to the person in Section 1. ***Example: self, wife, husband, grandparents, friend, daughter, stepchild, nephew, etc.***

Question 17:
Write the complete address, if different from the address in Section 1. ***Example: child is in college and living at school.***

Question 18:
Indicate gender of each person.

Question 19:
Indicate the marital status of each person listed.

Question 20:
Write the name of the spouse of any married minors living in the home. Any income of the spouse must be listed in Section 4.

Question 21:
Write month, day and year of birth for each person.

Question 22:
Tell us if this person is pregnant. If "Yes," tell us the due date.

Send proof of pregnancy from a Doctor's office or a clinic within 60 days to continue receiving full Medi-Cal benefits. You do not need to send verification if you only want pregnancy related services.

Question 23:
Check "Yes," if person is blind or has a physical or mental illness that is expected to last at least 30 days. If person is unable to work, check "Yes," and check the box that best describes how long the person will be unable to work if declared disabled. This will help us decide if you are eligible for Medi-Cal based on disability.

Question 24:
Tell us if anyone has ever had cash aid, SSI, Food Stamps or Medi-Cal. This will help the local welfare office check for needed information before asking you to give it. If you checked "Yes," tell us the name you received benefits under.

Question 25:
If you have ever received Medi-Cal, tell us your Medi-Cal Benefits Identification Card (BIC) number if you have it.

Your Medi-Cal Benefits Identification Card (BIC) number can be found here.

Question 26:
Check "Yes," if you are asking for medical benefits for this person.

Question 27:
Tell us if you own or are buying a home outside California. Your answer helps us determine your residency.

Send proof of California residency. You can use your proof of income as proof of residency, too. If your income is not from California, send other proof of residence. For example: rent receipts, utility bill or a child's school records.

SECTION 3

Answer for *all* children in Section 2.

Question 28:
Write the name of the natural or adoptive mother of each child. Check the box to tell us if the mother is employed, disabled, unemployed, deceased or absent from the home.

Question 29:
Write the name of the natural or adoptive father of each child. Check the box to tell us if the father is employed, disabled, unemployed, deceased or absent from the home.

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SECTION 4

List *all* income/money received by persons listed in Section 2.

Questions 30 and 31:

Use a separate line for each person who receives money. If a person receives money from two different places, use two lines.

***Example:** if the applicant has two jobs, use one line for each job to report her/his earnings.*

Question 32:

Write the amount of money you receive each time.

Example:
if you get money once a week, write the weekly amounts in the box.

If the money amount changes from time to time, put the average amount you get on a regular basis. We use pay stubs or other documents you give us to figure out the correct monthly income.

If you know your family's income will go up or down in the next few months due to overtime, promotion, raises in pay, expected increases in child support/ alimony, layoffs, furloughs, etc., explain on a separate sheet of paper.

***Example:** Maria's gross income from her job on this check is $1000 but her regular monthly pay is only $800. Explain on the paper that Maria's paycheck included $200 overtime pay, or a cash bonus and how long the overtime will last or how often she gets bonuses.*

Question 33:

How often do you receive this money?

***Example:** Monthly (once a month); weekly (once-a-week); biweekly (every other week); bimonthly (twice a month); or daily (every day).*

Documentation of Income

- **Send proof of income.** Send a copy of the most recent pay stub you have. If a pay stub is not available, get a signed statement from your employer. Gross monthly income and the dates received should be on the statement

OR

- **A copy of last year's federal income tax return.**

OR

Other proof of income you may need to send:

- If a person is self-employed, send last year's federal income tax return, include Schedule C, or the last 3 months' profit and loss statements.
- If a person has income such as disability or retirement, send copies of award letters or bank statements showing the direct deposits.
- If anyone gets child support and/or alimony or spousal support, send copies of the checks received or statements from the District Attorney's Family Support Division for the last month.
- If anyone gets student loans or grants, send in copies of award letters or loan papers.

SECTION 5

Give information about the listed expenses/costs paid by *all* persons listed in Section 2.

Tell us if you pay court-ordered **child support,** or **alimony,** or have other **health insurance or Medicare** premium costs.

Medi-Cal will pay your medicare premiums and deduct the cost of any other insurance premium from your countable income.

Question 34:
Write the name of the person who pays the cost.

Question 35:
Write in the total amount paid each month.

Question 36:
Write in the costs paid for child care and/or disabled dependent care.

Question 37:
List the age of the child or disabled dependent.

Question 38:
Write the name of the person who pays the cost.

Question 39:
List the total amount paid monthly for each child or disabled dependent.

Send proof of expenses (costs) listed in Section 5. Send in proof of child support or alimony costs. For childcare and dependent care, send receipts or cancelled checks.

SECTION 6

Skip this section if you are only applying for Children under 19 and/or pregnant women applying for pregnancy related services only. Otherwise answer for *all* persons listed in Section 2.

If you have questions or concerns about completing Section 6, leave it blank and contact the local welfare office for help.

The value of the home you are living in is not counted for Medi-Cal

Question 40:
Tell us the amount of all cash you have on hand and the amount of any checks you have received but not cashed.

Question 41:
If anyone listed has a checking and/or savings account or life insurance policy, please send copies of the following documents:

- Account statements showing current balances in accounts.
- Copies of all life insurance policies.

Question 42:
If you checked "Yes," send us a copy of the vehicle registration(s) or pink slip(s) or estimate(s) of value from a qualified source, such as a dealer or mechanic.

Question 43:
If you check "Yes," send us copies of all court orders, documents and agreements.

Question 44:
If you check "Yes," send us copies of your policies, contracts and purchase agreements. If your policy is certified by the California Partnership for Long-Term Care, give us a copy of your most recent benefit statement.

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Questions 45-47:
If you check "Yes," you may be asked to provide additional information. You may also have to fill out a property supplement form.

SECTION 7

Answer *only* for persons who want Medi-Cal.

Question 48:
A Social Security number for each person applying for full Medi-Cal benefits is required. If you do not have a Social Security number, do not delay sending in this application. You can apply now and give us the number within the next 60 days.

Pregnancy and emergency care services may be available to persons who are unable to get a Social Security number.

For information on how to apply for a Social Security number, call Social Security Administration toll-free, 1-800-772-1213.

Question 49:
Write the place of birth for each person. If born in the United States, write the name of the state. If born outside the U.S., write the name of the country.

Question 50:
Check "Yes" or "No," telling us if the person is a Citizen or U.S. National.

Give immigration information only for people applying for health coverage. Do not give information for people not applying. The State will use this information only for eligibility determination. Information about immigration is private and confidential.

Immigrants who meet all immigration requirements may get **full Medi-Cal benefits.** Undocumented immigrants can get pregnancy related and emergency services.

Send proof of immigration status or an INS receipt showing that you applied to replace a lost document. Many immigrants may get full Medi-Cal even if they do not have a green card or immigration document. Copy both sides and send now or within 30 days of application. If you do not send this proof, you may still be eligible for emergency or pregnancy related services.

Do not give immigration information about people who are not asking for Medi-Cal. Information about immigration is private and confidential.

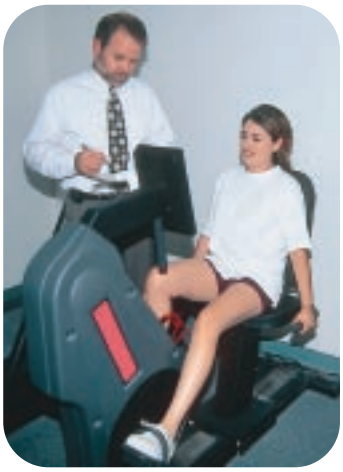
Question 51:
Tell us if the person is in a nursing facility, residential, or board and care facility. If you check "Yes," tell us the name of the facility.

Question 52:
Check box to show if each person has other health insurance coverage.

You can get Medi-Cal and still have other health coverage. Medi-Cal may cover what your other health coverage does not.

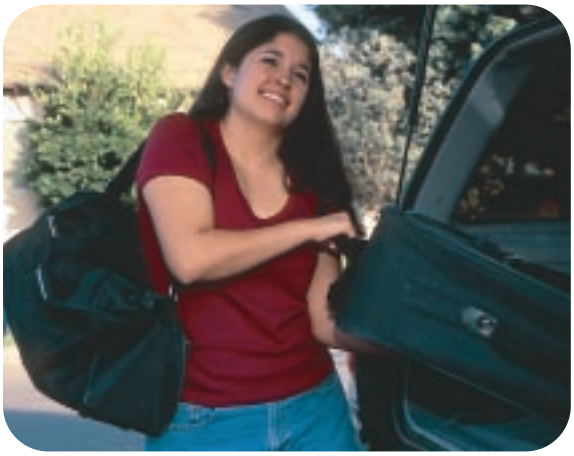
SECTION 7 Continued

Question 53:
If you check "Yes," Medi-Cal may be able to help pay some or all of the paid or unpaid medical costs you have had in the 3 months before you apply.

Question 54:

Check "Yes," if any person has filed a lawsuit because of an accident or injury, workers compensation, or car accident.

Question 55:
Check box(es) to show if individual, spouse or parent of individual is or was in the U.S. Military. We are asking for this information to see if you can get other services or benefits.

Question 56 (Optional):
You can choose to enter the Ethnicity (race) for each person. This information is used for statistics only and has no effect on your eligibility for Medi-Cal.



Question 57:
Check box to show if person is in school. The earnings of a person under 21 years may not be counted if the person is attending school.

Question 58:
Tell us if the person is living away from home, is away at school, or out of town working.

SECTION 8

Information Release (Optional).

Question 59:
Check "Yes," and the local welfare office will send this application to the Healthy Families program, if one or more of the family members applying do not qualify for the Medi-Cal program.

The Healthy Families Program provides comprehensive health, dental, and vision coverage for eligible children and adults. For further information call **1-800-880-5305** or visit their website at www.healthyfamilies.ca.gov

Question 60:
If you fill out this item you are telling the local welfare office it is okay to give information about your application to the persons you have named.

SECTION 9

Signature and Certification.

Who can sign this application?

- The person who wants Medi-Cal, or the spouse of the person who wants Medi-Cal
- The conservator, guardian executor, or caretaker of a child who wants Medi-Cal
- Someone acting for the person who wants Medi-Cal when the person is incompetent, in a comatose condition, or suffering from amnesia and there is no spouse, conservator, guardian or executor
- Persons 14 to 21 years old if they are not living with a parent, caretaker relative, or foster parent
- Persons 14 to 21 requesting Minor Consent Services

Question 61:
State and federal laws require your signature on this application form. Your signature in this section indicates that your declarations and answers are truthful and the documents you submit are true and correct.

Medi-Cal Confidentiality Notice

The information given in this application is private and confidential under Welfare and Institutions Code 14100.2.
The information will be disclosed only in accordance with those laws.

Medi-Cal Rights, Responsibilities and Declarations

I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
- Ask for an interpreter.
- Ask for a fair hearing if I think a decision on my Medi-Cal case is unfair or wrong. I must ask for a hearing within 90 days after I get a "Notice of Action". To find out about Medi-Cal fair hearings, call toll-free, 1-800-952-5253.
- A face-to-face interview.
- Review Medi-Cal program rules and manuals.

I have the responsibility to:

- Report any changes within 10 days in the information I give on this application.
- Let local welfare office know if a family member applies for disability benefits; is in a public institution; or gets medical care for any accident or injury caused by another person.
- Cooperate if my case is reviewed.
- Apply for available income.
- Cooperate with appropriate paternity determinations and medical support enforcement efforts.
- Assignment of rights to medical support to the State of California.
- Assign rights to third party medical support to the State of California.

I understand that:

- As a condition of Medi-Cal eligibility, all rights to medical support are automatically assigned to the State of California.
- If I purposely do not give needed facts, or if I give false facts, I understand benefits may be denied or ended and repayment may be required. I may also be investigated for fraud.
- Persons I am applying for are not in jail, prison, or any other correctional facility.
- After my death, the State has the right to seek repayment from my estate for all Medi-Cal benefits I receive after age 55 unless I have a surviving spouse, minor child(ren), blind or permanently and totally disabled child(ren).
- If I am admitted to a nursing facility and I have no intention of returning to my home, the State may impose a lien against my property.

Medi-Cal Privacy Notice

The Information Practices Act of 1977 and the Federal Privacy Act require the Department of Health Services to provide the following information: Welfare and Institutions Code Section 14011 and regulations in Title 22, CCR, require applicants for the Medi-Cal program to provide the eligibility information requested in this application.

This information may be shared with federal, state, and local agencies for purposes of verifying eligibility and for other purposes related to the administration of the Medi-Cal program, including confirmation with the INS of the immigration status of only those persons seeking full scope Medi-Cal benefits. (Federal law says the INS cannot use the information for anything else except cases of fraud.) The information will be used to process claims and make Benefits Identification Cards (BICs). Failure to provide the required information may result in denial of the application.

Information required by this form is mandatory, with the exception of ethnicity information, and any other item marked voluntary or optional. Social Security Numbers are required by Section 1137(a)(1) of the Social Security Act and by Welfare and Institutions Code Section 14011.2, unless applying for emergency or pregnancy related benefits only.

An individual has a right of access to records containing his/her personal information that are maintained by the Department of Health Services.

Contact your local welfare office to request your records.

Gray Davis
Governor, State of California

Grantland Johnson
Secretary, California Health
and Human Services Agency

Diana M. Bontá, R.N., Dr.P.H.
Director, California
Department of Health Services

Provided by the State of California

Flex your POWER